CHAPTER 7

Taking a History

Elizabeth Steiner

CASE 7-1

Mrs. Melinda Harrison, a 54-year-old woman, has just moved to this area. She comes to the office of Dr. Sarah Johnson to establish care and for a "complete physical." Dr. Johnson knocks, enters the room, and addresses the patient.

DR. JOHNSON: *Good afternoon, Mrs. Harrison. Welcome to our practice. I'm looking forward to getting to know you.*

MRS. HARRISON: *Hello, Dr. Johnson. I'm so concerned about so many things. I hope you'll have time to talk to me about all of them.*

DR. JOHNSON: *I'm glad you told me that you have several concerns. We'll do our best to address them during this visit and other visits if necessary.*

MRS. HARRISON: *Oh good!*

DR. JOHNSON: *Today we'll start by taking a complete history so I can learn all about you. First, I'd like to know more about your concerns. Tell me about them.*

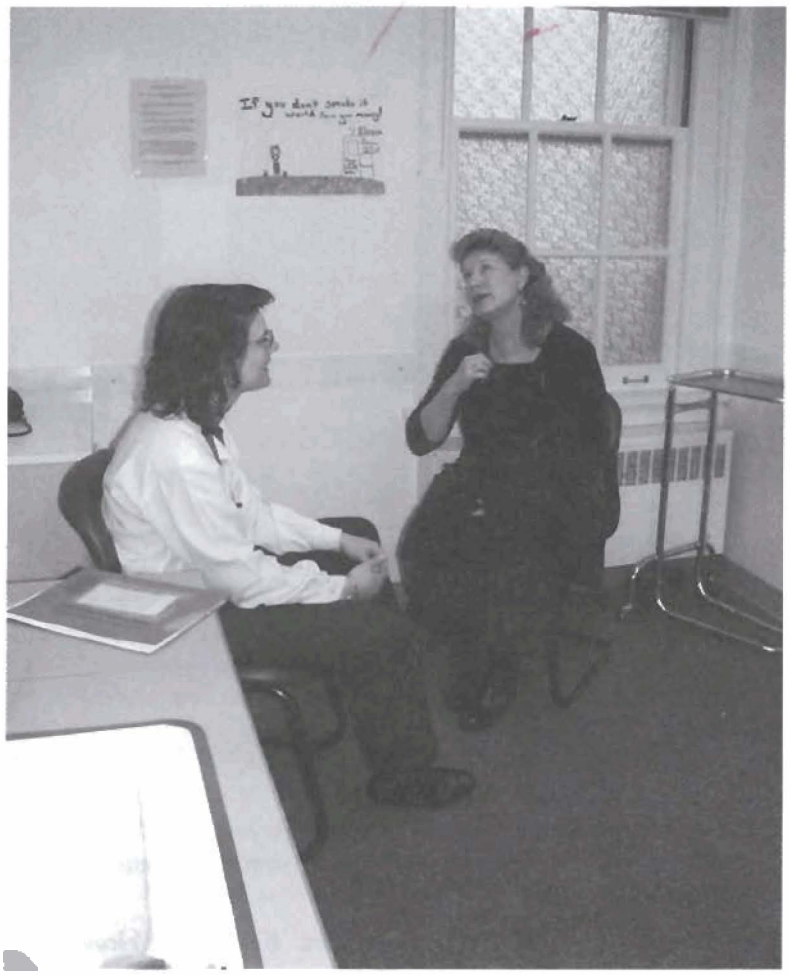
MRS. HARRISON: *Well, of course I'm having a terrible time with hot flashes ...*

EDUCATIONAL OBJECTIVES

1. Discuss interviewing techniques that facilitate history taking
2. Detail the components of a complete history
3. Describe a patient's pain complaint in an organized and concise fashion
4. State the difference between a complete history and a problem-focused history
5. Address issues of special situations: children, adolescents, pregnant women, the elderly, the mentally disabled

INTRODUCTION

Taking a history, whether that of a new patient or of an established patient with a new problem, is the physician's first and perhaps the most revealing step in the diagnostic process. Understanding the skills



Case 7-1. Dr. Johnson uses open body language as Mrs. Harrison's physical discomfort becomes evident.

required during a clinical conversation (Chapter 6) is indispensable; equally important is the physicians' awareness of what they need to learn about patients to help them improve their health.

At a time in medical history when diagnostic techniques based on laboratory assays are increasingly available, physicians can understandably challenge the significance of the medical history. Sometimes patients forget what they know; they may misreport; they may even conceal important elements while revealing matters that seem only tangential to their health. How reliable, how useful are their histories?

In fact, a well-designed medical history provides a solid foundation for all subsequent diagnostic and treatment decisions. Patients are whole human beings; illness or health affects the totality of their bodies and emotions. By listening carefully to patients' versions of their medical and surgical histories, their social and family histories, their accounts of work and leisure, physicians can learn a great deal about the specific circumstances that have brought them to the office. Physicians need to hear the unspoken assumptions or fears that lie beneath the patients' comments; they need also to be able to read their patients' gestures and body language. Listening skills must be combined with speaking skills; physicians need to know how to ask and restate questions, how to follow up on answers to those questions, and how and when to press patients to give fuller or more explicit answers.

Since patients are not the same, no single technique of taking a medical history will fit all situations. Yet the necessary information can be elicited and recorded in a systematic way, so that the passage of time between one medical visit and the next will not erode the physicians' understanding of their patients. Also, physicians do not practice in a vacuum; their colleagues, nurses, and other health professionals need to understand the patient as well. A complete history will help the medical team coordinate its treatment, and help patients continue the treatment once the physician discharges them. Such a history will allow physicians to note changes in patients' health, and to act early to forestall medical difficulties.

As many chapters in this volume point out, the skills that physicians need are developed through a lifetime of practice. What may seem excessively formal at first will become natural and easy as physicians interact with infants and the elderly, with those who are stable, those who are disturbed, and those who are angry, despondent, fearful, or uncomprehending. Each interview with a patient teaches physicians more about the patient and about themselves as physicians. This chapter will help begin the process of taking useful and dependable medical histories.

INTERVIEWING SKILLS

The previous chapter gives excellent examples of the medical interview as a clinical conversation, and points out strengths of good interviewing technique and weaknesses related to poor technique. In this section, we will discuss some of the more concrete aspects of interviewing, including open versus closed questions, body language, seating arrangements, normalizing language, and putting patients at ease.

As noted in Chapter 6, practitioners (physicians or students) must introduce themselves, and must ensure that patients are addressed in the way they are most comfortable. Generally speaking, it is always safer to take a more formal approach with adult patients, using their surnames until invited to address them by their given names. With children, one must take care to learn if they have a preferred nickname, and conversely, not assume that longer names are automatically shortened to a common nickname.

In the vast majority of situations, the open-ended question yields more information and more patient satisfaction than the closed-ended (yes/no answer) question. In addition, open-ended questions do not necessarily add time to the interview. Consider the following scenarios. In each case, Jane, a fourth-year medical student, is taking a history from Alan, a 20-year-old male with abdominal pain.

JANE: Alan, do you have pain in your abdomen?
ALAN: Yes.
JANE: Can you show me where it is?
ALAN: (pointing to his right lower quadrant) It's right here.
JANE: Did it start there, or somewhere else?
ALAN: It started around my belly button, and moved there.
JANE: Did it start today?
ALAN: No, yesterday evening ...
Time elapsed: 18 seconds

Or ...

JANE: Alan, tell me about your pain.
ALAN: Well, it started yesterday evening with some nausea, and discomfort around my belly button. By this morning, it was more like pain down here (pointing to his right lower quadrant).
Time elapsed: 10 seconds

In the second scenario, Jane got more information, in less time, and Alan felt more in control of the interview process, which increases his satisfaction with the encounter. There are clearly circumstances in which the closed-ended question is useful, and these will be considered later in the chapter.

CASE 7-2

Dr. White is talking with Sandra, a 15-year-old patient who complains of generalized fatigue.

SANDRA: *I don't know, some days I just feel as if I don't have anything good in my life. I'm just tired and miserable all the time.*

DR. WHITE: *You know, people who feel that way sometimes think about hurting themselves. Have you had any such thoughts?*

SANDRA: *Well, sometimes I wonder what would happen if I took a bunch of pills.*

Normalizing language, as illustrated by Dr. White in Case 7-2, allows the physician to ask potentially difficult or embarrassing questions in a way that puts the patient more at ease, and increases the likelihood that the patient will give an honest response. In Case 7 - 2, Dr. White uses normalizing language to elicit Sandra's thoughts of self-harm. Sandra may have been too embarrassed to answer honestly if Dr. White had asked, "So, are you thinking about killing yourself?" instead.

Finally, the physician's body language, seating arrangements, and the patient's level of undress will all affect the effectiveness of the history taking process. Physicians should maintain open body language, and if possible, should take a history sitting at the same level as the patient. The dynamic between patient and physician alters significantly if the patient is already in a gown, on the exam table, before the history is taken. Ideally, the patient should be sitting in a chair, with street clothes on, when the physician enters the room to take the history.

THE COMPLETE HISTORY

When a patient presents for a complete history and physical examination, or is admitted to the hospital for almost any reason, the most important task is taking a thorough history. As previously discussed, how you take the history can set the stage for all future interactions with the patient, and can often mean the difference between appropriate care and delayed care. In this section we will review the details of a complete history, along with mnemonics that can help you remember some of the many important pieces of a complete history. Developing a systematic way of taking a history will ensure that you do not forget to cover any part.

Over the years, physicians have developed a standard order for the complete history, and this is the order we will use here. While at times it may seem restrictive to use a standard format, doing so allows the reader to follow the history easily, and enhances communication among health care providers. Every written page of the history should be placed in the correct location in the patient's chart and should contain the patient's full name, date of birth, and medical record number if relevant. Notes should be legible, dated (and timed, if in the hospital), and signed with the writer's name and level printed under the signature (e.g., Andrew Gordon, MS I).

Finally, patients are often unclear about details of their history, or may omit important points through forgetfulness or embarrassment. Other sources of information, including medical records from other providers, hospital discharge summaries, and family members, can add substantially to the complete history.

Identification and Chief Complaint

Every history should begin with a standard introductory sentence. The sentence should contain the patient's name, sex, age, ethnicity or race, and the identity of the person giving the history. For example, "Amelia Anderson, a 78-year-old Italian-American woman, presents today with her daughter, Betty Johnson, who is the primary informant for the history." Alternatively, if the patient can provide the history herself, the last part might say "... with her daughter, Betty Johnson, and provides a clear history herself." While including race or ethnicity may not be relevant in all cases, it can provide important clues about specific

illnesses to which the patient might be vulnerable (e.g., thalassemia in patients of Mediterranean origin), about ways they might respond to treatment (e.g., African-Americans respond well to diuretics for hypertension), or about counseling that might be relevant (e.g., preconception counseling about Tay–Sachs disease for an Ashkenazi Jewish couple). Lastly, the patient's chief complaint, the symptoms that caused the patient to seek medical care, should be mentioned.

History of the Present Illness (HPI)

The longest section of the history is the HPI. In this section, you must convey in a concise, complete way all of the major issues for the patient at this time. Generally, in addressing each concern, you should include some variation on the "OPQRST" mnemonic (see Table 7.1). When asking about the patient's complaints, it is particularly important to use open-ended questions, allowing the patient to describe the symptoms in his or her own words. If the patient can't provide specific details, it is reasonable to offer choices ("Is the pain sharp or dull? Is it worse before you eat or after, or doesn't eating affect it?"). Clearly, the OPQRST mnemonic will not apply precisely to every complaint, but you can modify this useful tool as circumstances indicate.

In this section you should also include information about relevant Past Medical History (PMH), Past Surgical History (PSH), Family History (FH), and Occupational or Social History. For example, if Mrs. Anderson complains of chest pain, relevant history in this section would include previous heart or lung disease, family history of heart disease, her smoking history, and what is known about her lipid levels.

Allergy/Intolerance

Accurate and complete documentation of allergy and intolerance is critical to patient care. The list should include both true allergies (reactions such as urticaria, angioedema, and laryngospasm), as well as intolerance (nausea, headache, or other mild symptoms). Many patients will state they are "allergic" to a medication when in fact they have some intolerance to it. Physicians should help patients understand the difference between allergy and intolerance. Documenting intolerance as an allergy can limit therapeutic options unnecessarily. You should inquire about both allergy and intolerance to medications, foods, and environmental allergens (e.g., bees, dust mites). State clearly for each irritant whether the patient has an allergy or intolerance, and what symptoms the patient experienced.

Current Medications

Many substances qualify as medications, including prescription drugs, over the counter (OTC) medications, herbal preparations, and nutritional supplements. A comprehensive list of all such substances the patient uses currently (and sometimes within the past 6 months) permits accurate evaluation of possible interactions and adverse effects. The list should include strength, frequency, and indication for the medication, as well as the name of the healthcare provider who recommended the medication. Many patients consult multiple health care providers, including alternative practitioners, but may be reluctant to tell that information to a new physician. This is an ideal time to use normalizing language to elicit this information. "Mrs. Anderson, many patients get some healthcare from providers such as chiropractors or naturopaths. We can

Table 7.1
OPQRST Mnemonic

O—Onset	Date/time of onset of complaint. Can be specific date, or duration in days, weeks, etc.
P—Provocative/or palliative factors	What makes the symptom better or worse? Medications, body position, certain foods or environments?
Q—Quality	Describe the symptom. For pain symptoms, is it sharp, dull, achy, burning, etc.?
R—Region/radiation	Where is the symptom located? Does the pain radiate to another area?
S—Severity	How bad is it (a one-to-ten rating system can be helpful)? Does the severity vary or remain constant?
T—Timing	When does the symptom occur (time of day, related to eating or certain activities, etc.)?

all help you better if we work together. Do you see any other physicians or alternative healthcare providers? If so, what are their names and what medications or supplements have they prescribed for you?" If patients seem unsure of the details of their medications, ask them to bring all of their medications, in the original containers, to their next visit.

Immunization Status

Immunization records are an important part of any patient's medical history. Children require an extensive series of immunizations, and the recommendations for these change almost annually. As a result, you must inquire specifically about a child's immunization history, including types of immunizations, and number of doses of each. If possible, make a photocopy of the child's official immunization record for the chart. For adults, document dates of tetanus, influenza, pneumococcal, and hepatitis A and B immunizations. For women, document rubella immunity as well. Childhood illnesses such as varicella, measles, and mumps should also be documented, either by immunization or by clear history of the disease.

Past Medical History

The Past Medical History (PMH) provides a comprehensive overview of any significant past health events. It should include recurrent acute illnesses (e.g., streptococcal pharyngitis), chronic illnesses (e.g., diabetes), all hospitalizations, and the gravity, parity, and menstrual history for women. For each item, include the date (year is usually adequate), and any relevant information such as location (e.g., what city or hospital). It is also helpful to include related diagnostic procedures. Some physicians address habits such as tobacco, alcohol, and drug use in the PMH, while others do so in the Social History (see below). Information related to a woman's menstrual and reproductive history can be included in the PMH or in the Review of Systems (see below).

Generally, we present the PMH in outline form, rather than narrative (see Table 7.2). The PMH will give important clues about potential health risks or the etiology of current symptoms, and thus you should always take the time to discuss it thoroughly with the patient.

Past Surgical History and Hospitalizations

The Past Surgical History (PSH) states in outline form all surgical procedures and hospitalizations the patient has undergone. Again, the information should include the date, indication, and geographic location of the procedure or hospitalization. If relevant, you should reference the PMH for indication (e.g., 1997 Artery Bypass Grafting (3 vessels) 2nd to #3.1 above, San Bernardino, CA).

Table 7.2
Past Medical History Sample

1.0 Hypertension (dx 1975)
2.0 Tobacco abuse 60 pack-year history, quit 1997
3.0 Coronary Artery Disease (dx 1988) 2nd 1.0 & 2.0 above
  3.1 Anterior Myocardial Infarction 1997—San Bernardino, CA
    3.1.1 Angiography 1997 3 vessel disease, diffuse small vessel disease
  3.2 Mild Congestive Heart Failure (last echocardiogram 1998 LVEF 40%)
4.0 Chronic Obstructive Pulmonary Disease 2nd 2.0 above (dx 1990)
  4.1 Chronic Bronchitis
  4.2 Pneumonia 1995
5.0 Degenerative Disc Disease L5-S1
  5.1 MRI 1996

Social History

The Social History (SH) forms a cornerstone of patient care. By obtaining a complete SH, you and other physicians will understand the patient as a whole person, rather than as a set of unrelated medical problems. The SH also provides important information about activities that may predispose the patient to various illnesses and problems.

Taking a thorough SH requires patience, good interviewing skills, and a matter-of-fact approach, since patients may perceive many of the topics in the SH as "too personal" or the provider as being judgmental about the patient's behavior. Again, the use of normalizing and prefatory language will help the patient understand that your interest is in understanding the patient as a whole person, and achieving an accurate assessment of her health status. An opening statement such as "Now we're going to talk about parts of your life that aren't strictly medical, but reflect who you are as a whole person and aspects of your life that might affect your health. Some of these questions may seem very personal, but we ask them of all our patients, and your honest and complete answers will allow us to care for you better." The components of a complete SH and suggestions about ways to ask for the information are listed in Table 7.3.

Family History

The Family History (FH) provides important information about genetic risks the patient may have for various diseases. The FH should include current age/age at death and all significant health issues for grandparents, parents, siblings, and children. Especially in the case of established office patients, developing a genogram that reflects both FH and social interactions or tensions between the patient and family members will allow you to see patterns more clearly, and remember key aspects of the patient's social situation.

Review of Systems (ROS)

The ROS concludes the complete history. In the ROS, you inquire about any aspect of the patient's physical or emotional health not previously discussed. Again, the style of interviewing will determine the success of obtaining a complete ROS. Since the ROS is long, and can present multiple options to the patient, you must be sure to preface these questions with a comment such as "Now we're going to talk about you from head to toe, to be sure we haven't missed anything important. I'll be asking lots of questions, but if I go too fast, or you don't understand a question, please be sure to stop me." In asking these questions, you must

Table 7.3
Social History

Topic	Question to ask
Marital/living status	Do you have a spouse or domestic partner? Who lives at home with you? Are there other significant people in your life I should know about? Any pets?
Occupation/education	Do you work outside the home? What jobs have you held? Are you exposed to any toxic substances? How do you feel about your work? What is the highest level of education you completed?
Hobbies	What do you enjoy doing in your free time?
Cultural identification	How do you identify yourself culturally or ethnically? In what ways is this identification important to you?
Spirituality	Tell me about important spiritual or religious aspects of your life. How do your religious practices interact with your healthcare?
Tobacco use	Do you now or have you in the past used any tobacco products? If so, what, how much, and for how long?
Alcohol use	How much alcohol do you drink (quantity, frequency, how long, and any abuse)?
Drugs	What recreational or street drugs do you use now or in the past (get details)?
Sexual activity	Do you have intimate physical contact with men, women, or both? How many partners have you had in your lifetime? What concerns do you have about your sexual activity? (Sexually transmitted diseases should be listed under PMH or ROS.)

present each one individually, rather than as a list, which can be confusing. For example, when discussing constitutional signs and symptoms, ask "Have you noticed any changes in your weight? What about night sweats?" rather than "Have you noticed night sweats, weight changes, fever, chills, or increasing fatigue?" In this way, when the patient responds yes or no to a question, you'll know which question is being answered. The ROS is the only time in the interview process when the closed-ended question is preferred, since you want to be sure you have covered all relevant areas. For any positive response, you will then ask more detailed questions to understand the problem thoroughly. Again, while the list below notes medical terminology, you should "translate" those terms to lay language when asking the questions. Often, you may omit some questions from the ROS as circumstances dictate, but you should cover every area at some level.

General: fever, chills, malaise, usual weight, weight change (unintentional), fatigue
Diet: restrictions (by choice, religion, or intolerance), general style
Endocrine: polydipsia, polyuria, heat or cold intolerance, skin or hair changes
Hematologic: bruising, fatigue, lymphadenopathy, easy bleeding, transfusions
Head and neck:
- General—headaches (review OPQRST if yes), syncope, severe head injury
- Eyes—change in vision, diplopia, visual field loss, photophobia, pain, floaters, last exam
- Ears—tinnitus, hearing loss, infections, dizziness/vertigo
- Nose/sinuses—allergies, frequent infections, discharge, sense of smell, nosebleeds
- Mouth/throat/neck—dental history/last exam, sores, recurrent pharyngitis, dysphagia, change in voice, swelling/lumps

Respiratory: asthma/wheezing, dyspnea, pneumonia, recurrent bronchitis, asbestos exposure, chronic cough
Cardiovascular: chest pain, cyanosis, peripheral edema, orthopnea, exercise tolerance
Gastrointestinal: change in appetite or food tolerance, pain, change in bowel habits (pain, frequency, character), blood in/on stool, nausea/vomiting, gastroesophageal reflux, jaundice, dysphagia, fecal incontinence
Genitourinary: urinary frequency/urgency/pain/incontinence/nocturia/infections, sexually transmitted diseases, sexual function and concerns
- Males—penile discharge, erectile dysfunction, dribbling, testicular pain or lumps, hernias, contraceptive needs
- Females—menstrual history (menarche, frequency, menopause age, amount of flow, symptoms), reproductive history, contraceptive use history and current needs, intermenstrual bleeding, breast lumps/discharge, vaginal discharge

Musculoskeletal: fractures, arthritis, joint pain/swelling, bony deformity, weakness
Neurologic: vertigo, paresthesias, sensory loss, seizures, syncope, tremors, memory loss, weakness or paralysis
Psychiatric: depression, anxiety, irritability, sleep disturbances, general mood, verbal, sexual, or physical abuse

CASE 7-3

Jonathan Wilson, a 19-year-old patient, comes into the office complaining of a rash. As Muhammed Alasharifi, a second-year medical student, prepares to go in the room, the medical assistant tells him that the patient seems very nervous, and reluctant to answer questions. Muhammed notes from the chart that Jonathan has just finished his first year at college.

MUHAMMED: *Hello, Jonathan. I'm Muhammed Alasharifi, a second-year medical student. I'll be talking with you first today, before Dr. Baker joins us.*
JONATHAN **(sitting with arms folded, not making eye contact):** *Umm, Hi.*
MUHAMMED: *What brings you to the office today?*
JONATHAN: *Well, I have this rash, and I'm kind of worried about it.*
MUHAMMED: *Tell me more about your worries.*
JONATHAN: *I'm worried something I did might have caused it.*